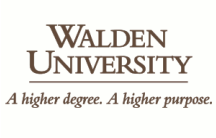

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Nursing Care of Terminal patients in Intensive Care Units

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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2015

Abstract

Nursing Care for Terminal Patients in Intensive Care Units

by

Pervell Dunbar

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

August 2015

Abstract

Although the goal of the ICU has always been to save lives, ICU now additionally provides end-of life (EOL) care. The objective of this project was to provide ICU nurses with a comprehensive awareness of physical, emotional, and spiritual EOL care issues of patients and their families in order to be better equipped to handle EOL care. The framework used was Jean Watson's Caring model (10 Caritas). A literature review revealed a poster previously used by a major health organization as a conversation starter to facilitate decision-making among ICU nurses, EOL patients, and their families related to EOL issues. The purpose of this quality improvement initiative was to introduce and implement an educational EOL tool that would engage patients and family members in meaningful and useful conversations with ICU nurses. Twenty seven ICU nurses were selected by the unit's director to attend a PowerPoint presentation on the use of the EOL educational poster. Four ICU nurses were chosen by the director to be champions for this project. After the presentation, there was a period for questions and answers, and the ICU nurses were requested to give feedback on the presentation. The result from the feedback revealed that EOL care is outside previous practice and may require extra education and support. These comments substantiated similar conclusions from other researchers as described in this paper. With an increase in EOL training for ICU nurses and the implementation of EOL teaching tools like the poster used in this study, ICU nurses may be better able to have conversations with EOL patients and families, thus improving patient care.

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Dedication

This project is dedicated to my mother whose passing has been 8 years ago. As I wrote this project, I realized how much I missed hearing her quiet hum as she performed her tasks around the house. I also dedicate this paper to all seniors, hoping that there will be some compassionate person at their bedside holding their hands as they take their last breath.

Acknowledgments

The experience of acquiring this terminal degree has been an arduous task, which I could not have done without the support of good friends who were my encouragers when I felt frustrated and tired of writing. I would like to thank Stephanie Paulmeno, my mentor and a great friend; her guidance, encouragement and support helped to steer me on the right path. I may not have said it enough, but thank you is not enough. Thank you to Brenda Anani, who was always willing to listen to my complaints, but was also ready with a word of encouragement. Thanks to Cynthia-Brown for all your help and encouragement throughout this journey.

Thanks also go out to Dr. Betty Ferrell for her support and her ready responses to all my questions and for books, and teaching materials that were very helpful for this project.

To my daughter Nicole, who many times would utter such kind words of encouragement when she noticed my sadness, sometimes even stopping to say a prayer when she saw how tired I was. To my son Phillip who was my cheerleader, who always told me how proud he was of me. I am looking forward to the birth of his daughter (my first grandchild) whose birth will be in July. My siblings Ruth and Bobby who were always ready with words of encouragements I love you all very much. Thanks for your unconditional love and support.

Last, but definitely not least, to my faculty committee members, Dr. Colleran-Santos, my chair person, for all your support and the extra push you gave when you saw there was a slump in my activities. Thanks to Dr. Janice Long who was always ready to listen to my complaints and even my cries, but her responses were always to cheer me on.

Thank you all for accompanying me along this journey; I will never forget all your support.

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Section 1: Overview of Evidence-Based Project

Introduction

End-of-life (EOL) care has become a global concern over the past decade (Singer & Bowman, 2002). Nurses providing care for terminally ill patients in the Intensive Care Unit (ICU) are challenged by the opposing goals of prolonging life at all cost for all patients versus EOL care that prepares terminal patients to die with dignity. Given this dichotomy, the reasons terminally ill patients are admitted to ICU are unclear when, by virtue of being terminally ill, it is understood that their condition has reached a non curable stage. It is necessary to determine how ICU nurses handle this dichotomy, to evaluate their preparation to deal effectively with the emotional needs of dying patients and their loved ones, and to assess their capacity to initiate meaningful EOL discussions by using tools that will guide their conversations about essential topics that involve decision making about EOL.

EOL describes a timeframe or a transition from one state of declining health to an alternative state that will ultimately, and despite all efforts, end in death. The outcome of care for the dying, as for all patients and their families, is measured in their perceptions of that care (Bailey, Sabbagh, Loiselle, Boileau, & McVey, 2009).There are several variables that influence the quality of care administered to patients and their families during this time. Because the goal of ICU is to preserve life, transitioning from curative to palliative care has proven to be stressful sometimes to the point of tears for these nurses (Harris, Gaudet, & O'Reardon, 2014). Historically, feelings about EOL have varied depending on one's culture and beliefs. For many people it is accompanied by

fear; fear of the unknown, fear of being alone, fear for the well-being of loved ones who will be left behind, and fear of pain and suffering.

EOL care draws on a combination of nursing approaches and medical interventions that are necessary for facilitating the care of individuals who are in the terminal stages of their disease process. Many of these patients are usually admitted to ICUs because their disease processes have become complex due to comorbidities leading to the terminal stages that require tertiary care (Ellershaw, & Ward, 2003).

Admission to ICU can be frightening and overwhelming to patients and their families (Bailey et al. 2010). It is during these times that they look for supportive and compassionate care from ICU nurses.

Many times supportive care needs for terminally ill patients and their families is lacking because of the ICU environment, as healthcare professionals' care is focused more on saving lives, and death is often viewed as failure (National Institute for Nursing Research [NINR], 2012). At the same time, distraught family members often times have difficulty conceptualizing the care and are not able to make sense of all the technological equipment that is in use. They also may have difficulty making logical decisions for their loved ones (Farrell, Joseph, & Schwartz-Barcott, 2005).

Nurses, who lack clinical skills specifically in EOL care, may be new to ICU or are more focused on the technological skills and expertise with the complexities of the machinery and other equipment in the unit may not readily see the needs of these patients and their families. If nurses are not psychologically adept, or if there is a lack in knowledge about the scope and complexities of palliative care measures and theory, their care will be lacking in sensitivity to the emotional needs of patients and their families

(Bailey et al. 2009). If nurses focus solely on monitoring aspects of care, they might completely overlook the physical and emotional discomforts and pain that usually accompanies the dying process.

ICU nurses are required to tap into their repertoire of supportive and compassionate skills. They should obtain information about patients' wishes, values, and beliefs, by engaging family members in conversations about patient's needs, if they are unable to communicate for themselves. Because of the technical culture of the ICU (Adamson, & Lynn, 2003), decisions made by family members can be negatively impacted due to the inadequate preparation of ICU nurses in caring for terminally ill patients. Having effective conversations with patients and/or their family members helps decrease family stress, which makes participation in the decision making process for their loved ones easier (NINR, 2012).

Problem Statement

For this project, I addressed the problem of nurses' lack of knowledge in EOL care. Nurses have the most contact with patients during their hospital stay, and it is expected that they are adequately trained to provide the care needed to all patients. Yet, a gap exists when it comes to ICU nurses caring for terminally ill patients. Mallory (2003) stated that a nurse's anxiety and the lack of adequate education affected caring for the dying patient. The use of End of Life Nursing Education Consortium (ELNEC) was found to help nursing students' transformation in this process. Likewise, Beckstrand and Kirchoff, (2005) stated that caring for patients at EOL evokes stress in nurses who have not been adequately trained to give care at this level.

Purpose Statement

My purpose for this project was to develop an educational tool that would help ICU nurses be more proactive in having conversations with terminally ill patients and their families. My goal was to equip nurses with the knowledge and supportive skills necessary to guide families with their decisions as they relate to EOL care. Ferrell, Grant, and Virani, (1999) identified the inadequate education of nurses as a major barrier to EOL care. Nurses' lack of experience and skills dealing with death and dying patients can lead to fear as they examine their own mortality (Harris, Gaudet, & O'Reardon, 2014).

Goals and Objectives

I proposed this quality improvement project to provide a comprehensive awareness of nurses in ICU, focusing on their educational skills in caring for the physical, emotional, and spiritual EOL care issues. Through the introduction and implementation of an educational assessment tool, nurses will be encouraged to become engaged in effective communication with their patients and families. The intent of this tool is to help initiate patient and family conversations with ICU nurses, conversations that tell stories about the patient, showing their life before their current illness.

By humanizing the patient, nurses can establish trust by learning personal details about their patients, such as what foods they like and what name they like to be called. Having conversations like these can easily lead to nurses asking other questions, such as whether or not the patient has an advanced directive and which member of the family should receive information about his/her condition. Important information garnered from having these conversations can be passed on to the medical team involved in the patient's

care; at times, this information may aid a provider's decision to add or change the current plan of care.

The tool, in the form of a poster, is proposed to create a relaxed and less stressful environment for patients and families. Sharing the stories of their loved ones before their illness will help to decrease the patient and family members' anxieties. It is also helpful to get the family involved in filling in the patient's information and adding pictures to complete their stories. It is intended that the poster will engage the other medical team members in meaningful conversations while learning more about patients' culture, values, and beliefs. In addition to the use of the poster to initiate conversations, nurses may be made aware of their own mortality and will perhaps reflect on their own attitude towards terminally ill patients and their families. I hope to use findings from this project presentation to improve communication among nurses and the dying patients and their families, thereby improving the care given to patients in ICU who are terminally ill.

Significance of the Project

During the early 20th century, the average life expectancy was 50 years and few people lived to the age regarded today as normal. Many died from infections that could be remedied today by medical and pharmacological interventions (Center for Disease Control, 1999). In those days, medicine and pharmacology, as is known today, were in their infancy of development; today, there is a greater awareness about health and wellness and diagnostics and pharmacological interventions, all of which impact EOL care (CDC, 1999). With the advancement in science and technology, the focus has now turned to aggressive therapy or prolonging life at all cost (Adamson & Lynn, 2003).

Patients experience more physical symptoms now than they did in the early 1900s when mortality rates were higher. Today, illnesses have a greater morbidity rate because of the various monitoring and life-saving equipment and with that comes psychological distress (Adamson & Lynn, 2003).

The expanded role of nurses while caring for a dying patient as stated by Haisfield-Wolfe and Lynn (1996) is nurses' attitudes towards death must be changed. They believed that there should be continued evaluation of nurses' care of terminally ill patients as death is an inevitable experience for all creatures and should not be viewed as a failure.

Globally, there has been an increase in the average life expectancy of people 65 years and older. Hogan, Lunney, Gabel, and Lynn, (2001) estimated that by the year 2030 adults in the 65-year old group will have doubled to 70,000,000 and adults in the 85-year old group will be more than 9,000,000. With this projected increase in the aging population, nurses can expect that they will be administering EOL care for an even larger number of patients; hence, it is important for nurses to be educated and proficient in caring for patients throughout their dying process through EOL care. Thacker (2008) identified fear as one of the barriers of nurses acting as advocates for the dying patients; it is during caring for a dying patient that nurses are forced to realize their individual fears.

Caring for patients at EOL has become a major concern for the United States as well as in the local healthcare communities today; providing EOL care needs to be made a priority. Annually, 2.4 million deaths occur in the United States, 80% of which occur in hospitals. Of these numbers, patients 65 years and older consist of 11%Medicare patients

who spend more than 7 days in ICU and end up dying shortly after their admission (Centers for Disease Control and Prevention [CDC], 2009).

In 2010, when palliative care was introduced in ICU as a screening criterion to meet the supportive care needs of terminally ill patients, the team identified barriers that affected nurses giving quality care to these patients. They saw a need to have resource nurses in the ICU to help educate staff in EOL care (Harris, Gaudet, & O'Reardon, 2014). Organizations such as the American Nurses Association (ANA) realized the need for ICU nurses to receive the knowledge and skills that are necessary to give good care to dying patients, and provided protocols and statements that helped guide nurses through the process of caring for the terminal patient. In 2000, the American Association of Colleges of Nursing (AACN) developed a national education initiative called End-of-Life Nursing Education Consortium (ELNEC). This program was designed to train palliative care nurses so that they, in turn, could train other nurses, including practicing nurses and student nurses.

Clinical Practice Guidelines for Quality Palliative Care were published in 2009 as another educational guide that could be used in ICU. All these tools can be used to promote good quality care for EOL patients. The Robert Wood Johnson Foundation funded and supported efforts that aimed at improving quality care of patients in the ICU at their EOL. Both clinical and didactic education is needed in EOL care in ICU for all nurses but more so for the newer nurses. Beckstrand et al. (2006) suggested that in addition to the education of nurses, physicians, respiratory therapists and other ancillary staff should be included in this training to obtain good quality outcomes.

Implications for Social Change

One of the many benefits of a Doctoral Nursing Practice Candidate is leadership; it is having the skills to work within an organization that impact changes in the quality of patient care by using strategies focused on quality improvement while at the same time ensuring patients' safety (AACN, 2006). This poster "Get to Know Me," is an educational tool that will be used along, with a few ELNEC questions, for use in the ICU. It will serve as a guide for nurses to learn about the importance of human relationships and effective communication as they care for patients who are dying and as they help guide family members in their treatment options and decision making. I hope that by introducing this project to a small unit, the success and acceptance of this tool will impact the quality of patient care and other units will follow suit.

Project Question

Researchers reported ICU health professionals are not readily accepting death as a life event, and thus are diminishing society's understanding of this life process (Haisfield-Wolfe, 1996). Pondering reasons for this behavior in this environment, I had many questions evolve as an effort to guide this educational project that will help nurses examine the quality outcomes of these patients and their families. The main question I sought to answer was the following: How effective is the training of ICU nurses in EOL care?

Definition of Terms

EOL Care: Care given to patients who have advanced terminal conditions that have progressively gotten worse and have been made incurable. It is the supportive and palliative care rendered until death ensues (nia.nih.gov/).

Palliative Care: Care given by an interdisciplinary team of medical professionals; their care focuses on providing patients with serious illnesses, relief from pain and stress caused by their illness. It provides that extra layer of support for patients and their families. Through their assessment, the team can identify early onset of psychological and spiritual needs and give support to these by offering help or recommending resources that can help. Palliative care is used in conjunction with curative therapies and is appropriate for all age groups (World Health Organization).

ICU: A designated unit in hospitals where patients who require specialized care or life sustaining treatment are cared for (medicinenet.com).

Intensive care nurses: Registered nurses sometimes called critical care nurses who have received additional training and education that equipped them to work in the ICU to care for patients needing many life sustaining care modalities (medicinenet.com).

Effective Communication: This means getting a message across in a clear and concise way, ensuring that the message is received and understood properly. Communication can be verbal or nonverbal (Businessdictionary.com).

Collaboration: Working together towards a common goal (www.aiim.org).

Comorbidity: When the same person has more than one chronic condition (National Institute on Drug Abuse). (drugabuse.gov/).

Caring: Displaying warmth, love, and compassion (Watson, 2007).

Humanistic: Having human regard or respect for others (Cambridge Dictionary online). (dictionary.cambridge.org/us/).

Advocate: Refers to the work a nurse needs to do to obtain the best care for a patient (nursetogether.com).

Assumptions and Limitations

Assumptions

1. Nurses experience moral distress when caring for terminally ill patients (Beckstrand & Kirchoff, 2006).
2. Nurses are not adequately trained to care for dying patients (Chiplaskey, 2001).
3. Nurses are not always aware of the symptoms of the dying patient (Kirchhoff et al., 2000).
4. Novice nurses are ill prepared to care for the dying patient (Cavaye & Watts, 2010)
5. Nurses have poor communication skills when caring for patients at EOL (Harris, Gaudet, & O'Reardon, 2014).

Limitations

1. There was not enough time allotted to attendees by the unit director due to staffing issues.
2. Only one small ICU was available for the implementation of this project.
3. Nurses were fearful of retribution and punitive actions from the medical team because of their interaction with the patients' plan of care.

Summary

Section 1 is an introduction to the issues that terminally ill patients and their family members experience as they are admitted to the ICU despite the knowledge of their disease trajectory, which over time has worsened. Patients are exposed to prolonged treatment modalities even in the face of deterioration of their condition. Haisfield-Wolfe

(1996) stated that the contemporary approach towards death has diminished society's understanding of death as a natural life event. For this quality improvement project and with the aid of an educational tool, I will teach nurses in ICU how using a poster can stimulate conversation and how its use can help with the dissemination of information on communication. Effective communication between nurses, EOL patients, and family members is lacking, which is affecting quality outcome of patient care (Harris, Gaudet, & O'Reardon, 2014). The Robert Wood Johnson Foundation, National Cancer Institute, and other organizations have funded programs such ELNEC to train nursing schools faculty members. This program is directed by the AACN (2014).

If conversations about the wishes of their loved ones are started with family members at time of a patient's admission, many futile efforts could be averted and palliative care teams could be involved early in caring for these patients' symptoms while offering comfort care to patients and families. Curtis (2004) suggested that clinicians and physicians become aware of the need for communication with patients and families as an effort to decrease family stress while enhancing their EOL decision making process and decreasing healthcare expenditures. Many patients, if given the choice, would rather die at home having their loved ones at their side than in a hospital ICU, thus decreasing Medicare spending per capita (Rice & Estes, 1984). In the following sections, I will share the findings of researcher's studies as they relate to ICU nurses and their communication with terminally ill patients and their families.

Section 2: Review of the Literature

Introduction

While some might think that an ICU is a quiet and efficient environment, in reality, it is the opposite. Most ICUs bustle with noise and activities, intimidating most people through beeping monitors, IV pumps, and other equipment. Patients are connected to countless pieces of medical equipment as they undergo numerous tests and procedures. Often times, because of the immediate and complex care that is needed, families are moved to waiting rooms outside the unit, without thought of even asking about patients' wishes, likes, or dislikes regarding treatment. Thelen (2005) stated "communication and relationships with patients and families can be lost in the intensity and technology of ICU" (p. 35).

Literature Search Strategy

I electronically searched for literature pertaining to EOL care using the following databases: ProQuest, Cochrane Library, CINAHL, and Medline. The terms and phrases that I used included the following: *End-of-Life Care, chronic diseases, terminally ill patient in ICU, advanced care directives, end-of-life decision making, quality care at EOL, death and dying in ICU, nurse's perception, nurse's communication, patient outcomes, palliative care, hospice care, bereavement, nurse's education in EOL care,* and *ELNEC.*

Specific Literature

Researchers in EOL care "state" (patient's body at time of admission) and "stage" (the disease process) report the topic as personal, expensive, and complex. It is a topic that impacts the lives of individuals, families, and society. Because of its complexities,

EOL care cannot be defined only in dollars and cents since there are so many facets of care that exist. Conway, Halek, Rosenberg, and Vallippan (2012) discussed the differences in cost for EOL care as it related to demography, race, and socioeconomic status. Medicare expenditures increase as patients' age increased. Medicare costs also varied according to where the patient spent his or her last days: Costs were highest if the patient died in the hospital and lowest if death occurred at home (Conway et al., 2012).

The aging population has increased the demand for healthcare services partly because of awareness of available services. Healthcare professionals need to be honest and transparent when having conversations about advance care planning with families; they also need to be comfortable when speaking about death and dying (Heyland, Dodek, Rocker, Groll, Gafni, Pichora et al. 2006). The National Board for Certification of Palliative Care (2014) supported this area of nursing practice as identified on its website. Nurses meeting the physical, psychological, emotional, and spiritual needs of patients and their loved ones who are coping with life-threatening illnesses are an integral part of palliative care, their services and supportive care continues through to the bereavement process (Chiplaskey, 2001). It has been identified that this goal can be accomplished through collaboration with the interdisciplinary team of health care workers.

Nurses' Knowledge and Skills in EOL Care

While nothing else in life is certain, death is a certainty; yet, it is seen as a failure by some medical professionals (AACN, 2014). Death is denied in the United States; because it is the belief that medical science can cure any patient.

Gaudet, Harris, & O'Reardon, (2014) addressed the fact that terminally ill patients who are admitted to ICU and their families depend on nurses' knowledge and skills for

their care. Gaudet et al. indicated that though nurses may have formal training in nursing, they often lacked the skills to comprehensively care for dying patients because EOL care methods were not offered in their nursing curriculum. Families also required the support of nurses when their loved ones have reached this stage of life; however, researchers have shown that nurses are not properly trained in EOL care, which includes the emotional care of families.

Ferrell, Grant, and Virani, (1999) identified this educational gap as a major barrier to EOL care for nurses. Realizing there was an urgent need that would guide ICU nurses, protocols were written and a national education initiative added, known as ELNEC, which created a focus on training nurses in EOL care (Ferrell, & Coyle, 2007). ELNEC curriculum is comprised of a series of eight training modules that were designed to teach nursing skills that would be effective in caring for patients at EOL. In addition to these, the AACN established 15 competencies that would guide nursing education; these competencies were thought of as being useful in nursing health assessment.

Chiplaskey (2001) identified that nurses were not educationally prepared to care for dying patients and recommended that there be an increase in nursing curriculum on issues of EOL care. Chiplaskey also advised offering continuing education for other healthcare professionals so that the standards of care given to dying patients would be improved.

Hansen, Goodell, Dehaven, and Smith, (2009) conducted a study of nurses in four ICUs at a medical center. Hansen et al. focused on the perceptions and knowledge of nurses giving EOL care to patients and families in the ICU. Hansen et al. reported that these studies had some limitations, and the tool used required further validation. The

researchers identified problems in care given to terminally ill patients and provided solutions and approaches on how these problems might be improved. The ICU nurses felt that their care for EOL patients and families was inadequate and that they needed support in this area of nursing. Hansen et al. provided information that could help guide nursing practice in EOL care; therefore, further study on this subject might include a focus on nurses' perceptions on EOL care for patients and families.

Communication in EOL Care among Healthcare Professionals

In a study of a large cohort of patients with advanced diseases that focused on testing the best way to support quality of life of patients with chronic conditions and their families, Heyland, and Dodek, (2006) discovered key elements that were important to these patients:

1. Their trust of physicians and clinicians involved in their care and treatment.
2. Life support measures that were not desired; would palliative care approach be included instead?
3. The degree to which there was effective communication from physicians and clinicians.
4. Continuity of care issues such as physicians and clinicians collaborating on care.
5. Effective patient's assessment along with support for patients and their families.

Heyland, & Dodek, (2006), showed that although other care elements were important these key factors listed above had a higher level of quality and relevance for

EOL patients. Despite patients' disease trajectories, patients still want control over making decisions while they are able to do so. Heyland, & Dodek, (2006) also noted some limitations regarding patients' and families as their preferences changed as death approached. Their ratings might have been influenced by being admitted to the hospital at the time of participating in the survey. Heyland, & Dodek, (2006) determined that more research is needed on nurses' and physicians' behavior and communication strategies that affect EOL care.

Culture and EOL

Costello (2006) conducted an ethnographic study to show the use of nurses' cultural knowledge as they cared for older, dying patients. Costello used a convenience sample of 29 nurses interviewed based on their experiences in a hospital setting. Semiotic analysis resulted in understanding the way nurses viewed death. For data interpretation, Costello used terms such as "good and bad deaths." Costello concluded that depending on what was happening in the ward at the time, as well as how the nurses understood death, death was viewed as a disruption to the normal routine. This perception determined whether it was a "good or bad death." The nurses actually focused on the event itself and not the needs of the patients and how well the nurse was able to fulfill the demands of the organization. Poor death was associated with staffing shortage, and good death referred to the nurse being able to function in his or her role at the time of patient's death. Costello stated that there was a need for effective communication with patients and families as it related to patients' prognosis, noting that the needs of dying patients should be prioritized over the needs of the organization or unit.

Understanding patients' values, beliefs, and spirituality helped nurses and physicians to begin conversations with patients to learn about their wishes and desires for their care. Kogan, Brumley, Wilber, and Enguidanos, (2013), in a cross-sectional study done to identify factors associated with physician referrals to EOL care; found that physicians were caring for patients with chronic conditions in their offices for up to 6 months prior to patients' death without referring them to palliative care. Kogan et al. recommended organizational training and education of physicians in EOL care to improve physicians comfort in having conversations with terminally ill patients and their families.

Palliative Care

Grant, Elk, Ferrell, Morrison, and VanGunten, (2009) discussed the changes in EOL care and palliative care in the United States through National Guidelines, multidisciplinary teams, and education, which showed some improvement in the care of patients with life-threatening diseases. Grant et al. discussed the newness of palliative care, and the support from stakeholders in helping to channel its growth. Team members received guidelines to follow when providing comfort care and managing patients' pain and symptoms. This procedure was not dissimilar to the tool used in this project for ICU nurses; this project is an educational tool, which will guide meaningful conversations about EOL issues.

Kirchoff, Spuhler, Walker, Vaughan, and Clemmer, (2000) stated that "three out of every four patients dying from cancer experienced significant periods of pain" (p. 37). Nurses who are taking care of terminally ill patients need to ensure optimal quality of life with comprehensive and compassionate care to promote comfort and relief of pain. Pain

control is a major component of all palliative and hospice cares because it is difficult to die with dignity when in pain. It is also a hardship for family members to watch their loved ones experience pain during their last hours before death.

According to Ferrell, and Coyle, (2010), "the goal to palliative nursing care, is to promote quality of life across the illness trajectory through the relief of suffering; this includes care of the dying and bereavement follow-up" (p. 3). The patient and his/her family becomes a unit of care, so caring for patients at EOL means caring for their families as well. The World Health Organization (WHO, 1982) defined palliative care as care given to patients who are faced with life-threatening diseases; the care for physical, psychological, and spiritual pain offered to these patients becomes the whole person care.

Technology in EOL Care

Beckstrand, Callister, and Kirchoff, (2006) indicated annual death rates of more than 2.4 million people in the United States. Of these annual deaths, most happened in hospital settings including 20% who were patients admitted to ICUs. Tilden (2001) stated, "Technological advancements in aggressive medical management at the EOL, have led more Americans to fear how they die rather than death itself" (p. 162).

Many patients during the dying phase of their disease trajectory maintain a sense of hope, respect, and dignity; this is important to them and their loved ones. Being admitted to ICU because of the decline in their condition, patients face aggressive therapy such as intubation and being placed on a ventilator, many times without physicians consulting family members to explain other treatment options. Many patients died without ever establishing trust in their healthcare team (Williams, Haskard, & DiMatteo, 2005).

Tilden et al. (2010) argued that because of the technological intensity of ICUs there is a breakdown in communication between nurses and patients. Tilden et al. further stated that because of this technological intensity of ICU, increased attention should be placed on improving communication with patients and families. In the Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatments (SUPPORT), it was shown that patients do have preferences for their EOL care but many were not given an opportunity to express their preferences. Because of this, the decision making was forced on family members. These family members were not given a chance to understand and process the information and responsibilities, nor were they given sufficient time to be comfortable with the decisions that they made. Decision making about EOL care has a long term impact on the lives of families so healthcare professionals should consider taking this process more seriously, allowing families and patients to take time for the processing of this information.

General Literature

Iran, Nayeri, Negarandeh, & Valiee, (2012) explored the experiences of ICU nurses who provided EOL care. They collected and analyzed in-depth interviews from 10 ICU nurse participants who described the feelings they experienced while observing reactions of patients' loved ones. Although a small study sample was used, Iran et al. revealed that caring for patients at EOL included emotional stress for nurses as well as patients' families. This stress placed a burden on nurses' own values and beliefs and also increased the current knowledge about the experiences of nurses caring for terminally ill patients. I used this study for this project as it added insight into the reason nurses working with terminally ill patients and their loved ones may experience difficulty

initiating and following through with meaningful conversations with those who are dying and their families.

McCourt, Power, & Glacken, (2013) examined nine studies by analyzing literature searches across the United Kingdom, exploring nurses in acute care settings, since they also provided EOL care to patients. From these studies, six themes emerged; they included nurses' lack of education and knowledge in caring for the dying patient. Another theme was the presence of communication barriers between nurses and patients. McCourt et al. focused on the different ways nurses around the world provided care for terminally ill patients and found there was room for improvement in EOL care. McCourt et al. recommended educating nurses about EOL care as well as modifying care to meet individual patient needs. The poster in this project will help nurses begin conversations with patients and families while garnering information that may be helpful to consider when developing patients' treatment options.

Clayton, Butow, Arnold, Martin, & Tattersall, (2005) carried out a qualitative study on the needs of terminally ill cancer patients versus the needs of caregivers to obtain information regarding prognosis and EOL issues. The data collected included face-to-face interviews as well as phone interviews. Participants included 22 health professionals, 24 caregivers, and 19 patients who were recruited from specialist palliative care services in Australia. The focus was on the perspective of health professionals, patients, and caregivers on the provision of information regarding prognosis and EOL care. Clayton et al. revealed that having consistent information is important to both patient and caregiver so that caregivers will have the correct understanding of the plan of care. The education/assessment tool used in this project has a similar function.

In a Dartmouth study, Goodman et al., (2010) noted that 1.5 million patients in the United States are diagnosed annually with cancer. Despite the poor prognosis of these patients, some physicians still aggressively offer treatment to these patients though they are aware that their treatments are actually futile even without having honest discussions with patients and their families. Many of these therapies are usually carried out when patients' conditions are too far advanced for any cure and adoption to palliative or hospice care is too slow, which leads to unnecessary pain and suffering within the last month of patients' lives. Patients with chronic illness in the last 2 years of life accounted for about 32% of total Medicare spending, much of it going towards physician and hospital fees associated with repeated hospitalizations (Goodman et al. 2010).

Conceptual Models

Palliative care teams give support and care to families whose loved ones are nearing the end of their disease trajectory. Therefore, "caring is an integral aspect of nursing, {as} it is the hallmark of effective nursing practice" (Finch, 2008, p. 25). Boykin, & Schoenhofer, (1993) described caring perspectives as a discipline of knowledge and professional service. Kolcaba, (2011) described comfort care as an immediate, desirable outcome of nursing with the following traits:

- Transcends comfort that enables patients to rise above the challenges that he/she might be facing by their decision making processes of EOL.
- Comprised that aspect of EOL care processes where the nurse assessed patients' needs and developed appropriate intervention that met those needs; this process allowed the patient's comfort level to be further evaluated to ensure the maintenance of effective comfort measures.

Caring stories by patients and family members convey to others the impact of patients' satisfaction scores of an organization. Do patients experienced such caring comfort in ICU? Watson's (2007) theory of caring suggested that the environment in which nurses give care should radiate a sense of nurturing that helps with caring while revealing the richness in nursing. Watson's 10 caritas for caring became valuable in the lives of patients who are terminally ill and their families as they experienced fear, anxiety and hopelessness.

Watson, (2007) listed the following 10 caritas:

1. Caring grounded in humanistic values that include kindness, empathy, and love for self and others.
2. Encouraging patients' beliefs, giving respect and honor, even when nothing else exists medically, and nurses nurture patients' hopes and faith.
3. Being sensitive to others, learning about others' views by cultivating one's own spiritual practices.
4. Developing and sustaining helpful, trusting, and caring relationships.
5. Listening to another person's story may be the greatest act in which a nurse can be engaged by just being authentically present.
6. Using all ways of knowing as he/she engages self in clinical caring.
7. Engagement in teaching/learning experiences while grasping the significance, timeliness, and readiness for the patient receiving the information.
8. Creating an environment that is full of spirituality, healing, comfort, safety and wholeness.

9. Assisting with the basic needs for patients such as caring for the mind, body, and spirit.
10. Openness to spiritual mysteries.

Fostering a relationship with someone to whom one feels committed defines caring. Watson, (2007) shared the knowledge of nurses being emotionally present as they offer supportive guidance to patients and families regarding their treatment options in EOL care. In addition to Watson's caring caritas, culture plays an important part; medical professionals therefore need to respect the many cultural differences they may encounter while caring for patients who are dying.

Coolen, (2012) searched the literature and conducted interviews with healthcare providers, and afterward shared the influential challenges of the variables that were impacting EOL care. Different cultures response to pain and their decision making norm varies from the American norm. Healthcare professionals should understand and recognize the uniqueness of a patient's culture, their behavioral norm, practices, and beliefs, as well as their preferences, as they render care to patients of different cultures (Coolen, 2012).

Summary

Nursing is considered a profession in which caring plays a pivotal part. Caring began back in the days of Florence Nightingale as she administered care to dying service men. Jean Watson, (2010) model on Human Caring has helped to form the framework for this project. LoBiondo-Woods, (2003) stated that caring for a loved one can be stressful; however, the contribution to the advancement of caring practices and current research could lead to interventions that would benefit both patients and their families. By

listening to what society is saying and trying to bridge the gap; by improving communication between terminally ill patients and their loved ones, will only lead to satisfied patients and their families.

With the rapid growth in culture in the United States, there is a need for healthcare works to be culturally sensitive to patients and their family's needs, especially when it comes to their healthcare needs; knowing what their likes and dislikes are and how they view their healthcare needs. Healthcare providers need to know cultural practices and which family member to speak with when having family meetings about patients' healthcare changes and decision making (Coolen, 2012).

Hospitals are now moving towards becoming patient-centered facilities as they strive to be supportive of both patients and their families, as they become supportive to patients and their families, as they point them to the resources that they may find helpful to their needs (Reiling, Hughes, & Murphy, 2008). Having effective communication with patients and their families despite their culture creates an environment of safety, trust, and hope in times of crisis and threat. Thoughtful clinical communication between healthcare personnel, patients, and their family members has the power to strengthen healthcare relationships.

Section 3: Design and Approach

My purpose for this quality improvement project is to develop an educational tool along with the intent of implementation and feedback from nurses in ICU. Using this educational tool, I hope to equip ICU nurses with the knowledge and skills that are necessary to guide terminally ill patients and their families through the dying process by having conversations that would add information regarding their wishes for their treatment for EOL care.

After receiving Institutional Review Board's approval, I did a PowerPoint presentation to selected staff chosen by the director of the unit; this presentation was quite interactive as the attendees were given a few scenarios for which they were able to respond with what actions should be taken. At the end of the actual presentation, I presented the "Get to Know Me" poster, showing nurses how it can be used in their unit. Attendees were asked to complete an evaluation of the information shared and to answer a few demographic questions. Based on the questions and the discussions of those nurses who attended the presentation, the general consensus from all attendees was:

1. The need for ongoing education and training in EOL
2. The fear of not knowing what to say to patients and families
3. The fear of retribution from medical team for talking to patients about EOL care options

Target Population

This project was introduced to the staff of a 12 bed Medical ICU in a Southeast Medical center in Georgia. I chose this particular ICU because it was the smallest ICU in the hospital and it has the most intakes of EOL patients. This hospital also housed an

active palliative care team and has an in-house hospice unit, which I found to be ideal for this project.

Educational Tool

The tool used for this project is an adaptation of an educational tool in the form of a poster that was successfully used at Massachusetts General Hospital, MA. Permission for use was granted by Dr. Billings a staff member of the MGH team. I introduced this poster for nursing staff in ICU to initiate conversations between patients, family members, and healthcare professionals. With the aid of this poster, nurses who are unsure of what to say to EOL patients and their families will become engaged in conversations about EOL care. I used the tool (Figure 1) to establish an alliance and to dispel fear and anxiety, and to establish trust between nurses, patients, and their loved ones.

Figure 1. Communication tool.

Evaluation of Project

My driving force for this project on EOL care in the ICU is to provide patient safety, increase quality care, and improve good outcomes for terminally ill patients and their loved ones during their last days. The successful execution of this program relies on the attentiveness and support of leadership for sustainability; for this reason, four champions were chosen by the unit's director to motivate their colleagues, which is vital to the program's success. Feedback from nurses and families who have used the posters

will determine if the project is a success; suggestions received from end-users will be incorporated to enhance the project's success.

Summary

Maintaining a sense of hope, respect, and dignity, while valuing patients' and families' cultural beliefs and spirituality is vital to successful EOL care. Nurses must also understand the patient and value those who are facing death as well as their loved ones. Family members are left behind to remember these last days; hence, memories from the busy environment of an ICU should allow for hope, compassion, and respect through the voices of nurses and attending physicians. Although hope for a cure in the case of terminal illnesses usually is lost, attitudes and respect from healthcare professionals contribute to quality outcomes and pleasant memories. Costello (2006) found in the research on patients dying "well" in hospitals that "good" deaths included ensuring that the patients' religious needs were met and that they were made as physically and psychologically comfortable as possible, which alleviated the concerns of their family members. This type of death affords families peace of mind knowing their loved ones did not suffer.

With the educational tool that was adapted for this project, it is hoped that nurses will have early conversations with patients and families, engaging them as they are encouraged to share the stories of the life of their loved ones before they became ill. By sharing these stories, patients' anxiety and mistrust can be dispelled.

The Institute of Medicine (IOM, 2011) and the Affordable Care Act have supported nurses practice to the full extent of their education, training, and licensure; but,

the IOM does acknowledge that nurses still require more education in order to adapt to the changes currently being implemented in healthcare reform today.

Section 4: Findings, Discussion, and Implications

There were 27 nurses who attended the presentation on this project, and, of those, only two nurses took additional training to learn about death and dying. The majority of attendees had more than 10 years of nursing experience. However, they all agreed that there is a need for education and training in this area of nursing. They expressed that their current knowledge, based on their experience in the field, did not negate their fear of speaking to patients and families about death and dying. Some shared that they did not feel supported by medical teams, though this hospital is a patient centered organization. Many nurses are not normally involved in family meetings.

ICUs are now caring for more terminally ill patients, yet many ICU nurses are not knowledgeable about caring for these patients. Many of the patients admitted to this study unit have chronic conditions, some with comorbidities. Having visited the unit after the presentation to follow-up with the champions to see what feedbacks were received and to answer questions, I observed that, to date, four posters have been implemented and families were ready and willing to complete the information. Only one family refused to participate in the poster usage.

The champions stated that during their huddle time at the beginning of the shift, the staff is reminded to initiate conversations and to evaluate their patients' diagnoses to see if they qualify for the poster usage.

There are challenges experienced as some nurses are not ready for the change. Champions are still encouraged to persevere with their encouragement and motivation of staff. Those staff members who did not attend the project presentation were oriented to

the use of the poster and were encouraged to have family members fill in the information if patients met the criteria.

I found through this project that there definitely is a need for ongoing EOL education and training for ICU nurses consistent with Harris et al.'s (2014) statement. This project was aimed at improving EOL care for those patients who are at the end of their disease trajectory. Though there were many nurses who attended the presentation who had more than 10 years of nursing experience, nurses with less than 5 years' experience had a similar amount of knowledge about death and dying as their more veteran counterparts. Both groups of nurses struggled to have effective conversations with terminal patients and their families and experienced anxiety when dealing with EOL issues. All nurses could benefit from education and training in death and dying and how to relate to these patients' loved ones. One limitation of this study was that not all staff members were able to attend the presentation; but, it is hoped that with the motivational efforts of the champions, the benefits of this project will be realized and will trickle down to the other units.

Implications

Caring for patients who are at the end stage of their disease trajectory and their families is not easy and working in an intensive care environment is just as the name of the unit suggests. Many times this type of care is found to be uncomfortable for nurses, perhaps from fear and facing their own mortality (Harris et al., 2014). Miller et al., (2001), stated that because of this uncomfortable situation that exists when nurses give care for dying patients, many tend to disengage themselves; the cause for disengaging

may vary from their observation of the futile care offered or from sheer ignorance of not knowing what to say to families. These factors can result in neglect in patient care.

The yield from this quality improvement study has implications for further study and educational training needed for nurses in the critical care setting. The care needed for dying patients and their families must be balanced with the care needed to preserve and prolong life, as this is the intent of ICU. Training will help support the challenges that nurses are faced with when caring for someone who is dying. Nurses need to be reminded that a caring relationship and a caring environment preserve dignity, wholeness, and integrity and offers authentic presence (Watson, 1999). Society is dependent on nurses to be knowledgeable and to offer guidance and compassion in their daily encounter with patients.

The nursing shortages have impacted the time and care that nurses offer, especially to the older and sicker population (Ford, 2012). Nurses should get the support and education that is needed to provide dying patients peaceful death.

Project Strengths and Limitations

The strengths related to this "Get to Know Me" poster were the ease of its introduction to families, using words that showed interest in getting to know the patient, knowing what they did before they became ill, and informing them that this tool has been used successfully before in a major organization. Nurses will find it easier to speak about the poster than the actual diagnoses of the patient; hence, there will be less tension and anxiety experienced by the nurse as well as the patients and their families.

The focus for this project was to adapt or create an educational tool for ICU nurses to use in EOL care. "A tool is an instrument (guidelines, surveys, or checklist) that

helps users accomplish a specific task that contribute to meeting a specific evidence-based recommendation or practice standard" (Agency for Healthcare Research and Quality ([AHRQ], 2013, p. 2).

The use of the poster as a tool, which was successfully used for the same purpose in another major healthcare organization, was designed for nurses to initiate conversations with patients and families. Nurses were told, if they present the tool using a nonthreatening approach, patients and families will be more apt to participate and tell their stories about the patient before he/she became ill.

The limitations for this Doctor of Nursing Practice (DNP) "Get to Know Me" poster, included the fact that not all nurses were able to attend the presentation or even the introduction of the poster at the monthly staff meeting. There was a lack of interest shown in this initial phase, but, with the four champions trained to answer their questions and their constant reminding shift managers to tell staff about the posters, interest and participation is expected to increase. Another limitation was the time constraint; approval from Institutional Review Board took longer than anticipated. Due to the wait, some staff members lost interest in becoming champions and took on other projects instead.

Recommendation for Remediation

Using the poster "Get to Know Me" will be a good way for nurses to engage patients and families. This approach allows nurses to humanize the patients, so that their knowledge of patients' beliefs and values can be imparted to the other healthcare professionals involved in patient care. Nurses are not engaging patients and their families in conversations about EOL care, and nurses should discuss patients' treatment options by involving other care team members such as palliative care team (Mohanti, 2009). ICU

nurses need more education about how to have effective conversations with patients and family members regarding EOL care (Chiplaskey, 2014). It has been suggested that this project be used as an ongoing educational competency for nurses.

Based on other research that resulted in the educational need for nurses in death and dying and EOL care, it is confirmed that the need still exists despite the ELNEC courses that are offered four times a year. In fact, many nurses were not aware that these courses existed. A copy of the ELNEC CD sent by Dr. Ferrell for me to share with the ICU nurses was given to the champions so they could make recommendations to their department heads for setting up ongoing educational training on EOL care for all nurses. I was not able to follow-up to see the result of this initiative. Perhaps bringing ELNEC training to hospitals is an area that future researcher could address.

Analysis of Self

This experience has been an amazing journey, one that was not without many pitfalls and hurdles. Nursing has been the only profession that I have had after leaving high school; I have more than 30 years of nursing experience. Having received my nursing education outside the United States, I found it very challenging at first to adapt to the informal ways of nursing in this country; yet, I also knew the opportunity to obtain further education was at my fingertips. I have been in school ever since. I am considered a forever student and now here I am completing my terminal degree as a DNP, a degree that many times during this process I asked myself, why.

As I prevailed and accepted the saying that “knowledge is power,” I felt that there was so much more that I have to do for humankind that I cannot have enough knowledge. I did not anticipate that the passage would be so tedious, but looking back at where I was

and where I am today, I am proud of all I have accomplished. I will admit I have grown and achieved great knowledge as I completed the final task of developing and implementing a project. I feel this is just the beginning of many projects. I am forever grateful for friends and mentors who gave me encouragement along the way.

I think I am a better nurse now, and I see the needs that exist in communities and in healthcare today, such as caring for the critically ill, and those at EOL. Though, for whatever reason, many people do not like to discuss this topic; this topic should be discussed because unlike everything else, death is certain. It is an experience we all will have.

As Scholar

To be a true scholar one has to have wisdom and to apply that wisdom to one's daily activity to help shape the world. The wisdom I gained in this process was from the many class discussions, the sharing of thoughts with peers, the feedback from faculty, and the research through literature searches, noting how others addressed similar topics in a different light. Networking with other scholars has added to my knowledge gained throughout this program. Many of these scholars have even become mentors, guiding me along and ensuring that I stayed on track.

I would like to see this project that I developed and adapted for the ICU nurses disseminated in other areas of healthcare. I have already been requested to speak on EOL within the pediatric population. I would like to find the medium where I will be able to speak to small groups, as many patients do not know their healthcare options and many are totally ignorant about advanced directives. Being a Certified Faith Community Nurse,

I am also looking at giving a presentation at an upcoming monthly meeting. Already, I have presented to leaders in the hospital and their feedback was encouraging.

As Practitioner

My adventure through this DNP program included receiving the respect from colleagues who recognized that my journey has truly been a sacrifice. Now they are witnessing that I am almost finished. It is a wonderful feeling of accomplishment; so much has been invested in this degree that I feel that there is so much that I need to contribute to society. I have nurses seeking my advice on various topics, some have been asking about returning to school. So far, because of my encouragement, six nurses have returned to school pursuing their Masters in Nursing with the plan to continue on to the DNP program.

Though my area of practice currently is with neonates and EOL care may not be as prevalent, death is seen across the continuum of life and parents need so much supportive care, sometimes for months. Nurses in this area need supportive care from leaders as they experience such moral distress. Recognizing that this is mentally draining, counselling is offered for the staff whenever there is a neonatal death, as there is not a neonatal palliative care team in this hospital.

As Project Developer

Planning and preparing for this project was exhausting; searching literature, rewriting the proposal while staying in the weekly class discussions and getting the practicum hours, oral defense preparation, and then finally waiting for Institutional Review Board approval. No one prepared me for this stress and frustration; but, I was

oftentimes reminded of a saying that my mother had: “There is light at the end of the tunnel.” I can say I am seeing that light, and it is not just a flicker now.

Here I am writing the final paper and many times I had to ask myself what am I going to do after this. I will not be sitting up at two in the morning writing a paper. I realize that every time I had to revise my paper, I gained better insight in what needed to be done. Throughout this journey, I have developed confidence in the task of planning and developing an evidence-based quality improvement project. I will use this experience to guide the planning of others, which I have no doubt will come my way.

Future Professional Development

This project was developed for use in a small ICU with the following goals:

- Increase awareness and knowledge of nurses in that unit about advanced care planning for terminally ill patients and their families.
- Increase ICU nurses’ knowledge in EOL care.
- Increase ICU nurses’ proactivity as they engage terminally ill patients and their families in conversations that deal with their treatment options.

My main goal for the poster is really a conversation starter, but it can be effective as patients and family members become engaged. As they share their story, patients become more relaxed, which enables nurses to ask other questions that are pertinent to patients’ condition. My intent is that the other ICUs will pattern its use as patients are transferred between units.

It is important for DNP scholars to maintain their professional development by seeking to work in areas that foster and enhance knowledge gained. Zaccagnini, & White, (2011) stated “Advanced practice nurses have a responsibility to define and refine the

philosophies and values informing our theories, our research, and our application of research" (p.9). It is the responsibility of the DNP scholar to become competent in his/her practice while ensuring safe patient outcomes.

Section 5

Manuscript for Publication

The responsibility of a DNP scholar is to share knowledge learned through research or practicum experience. Oermann, & Hays, (2010) stated that nurses can share the findings of their evidence-based projects through publications. It is through reviews of this literature that nurses gain knowledge and are able to disseminate their findings so that others can gather information that will guide their practice.

Because this project was done using ICU nurses as the population studied, my first thought of journal to use for publication would be *The American Journal of Critical Care Nurses*, and my second choice would be *British Association of Critical Care Nurses*. I have read the guidelines needed for submission and will give some thought to this in the near future. Both journals accept online submission and are peer reviewed before publication, the site seemed user friendly, and I am sure if needed, I will be guided accordingly.

Project Summary

In summary, this Quality Initiative Project resulted in the adaptation of an educational tool to bring awareness to ICU nurses on the importance of giving quality care to terminally ill patients and their families. I used this tool to show nurses how just being present in the room at the patients' bedside is comfort to both patient and family members. Reminding nurses how just having conversations with patients about things they liked to do prior to becoming ill means a great deal to them. Nurses learning how listening to patients and families verbalize their fear and anxiety is showing caring and personhood. In spite of being in a busy and chaotic environment such as ICU, nurses do

care and they can be guided in finding resources for answers to their questions if they do not have the answers themselves.

The main points that emerged from the discussion and question and answers after the PowerPoint presentation to the staff were the need for ongoing education and training in EOL care, the fear of not knowing what to say to patients or their families, and the fear of retribution from medical team when nurses become involved in EOL care. These points were also identified in literature that was reviewed, and I shared these discussion points with management. I hope that these findings will be given consideration for future research. Given the statistical figures that by 2030 the number of patients with chronic conditions and comorbidities will have tripled (Hogan et al. 2006), consideration should be given to bringing ELNEC within the walls of healthcare organizations so that nurses will have the knowledge to give quality care to this population.

Project Evaluation Report

Prior to the start of this project, I chose what issues my project would address and then I set goals as to how I would try to address these issues. Once the project began, I continued my evaluation to see if my intended goals were being achieved and to take corrective actions if needed. The ongoing evaluation served as my roadmap to see if I was close to reaching my goal.

There was no use completing the project without evaluating different aspects of the program to ensure everyone involved was aware of all activities, adding and deleting as the program planning design took shape. Evaluation tracks one's progress, which is necessary for a successful project. The weekly class discussions also helped as I examined suggestions received from peers. Another helpful evaluation was having

mentors to assess what has been completed and taking their critiques to enhance the finished project.

Prior to presenting this project to the ICU staff, I presented the PowerPoint presentation to a group of managers as an effort to have them assess how meaningful and sustainable this project could be and to have them critique and make suggestions on what the intended goals were. Their feedback was appreciated and a few corrective actions were addressed before my first presentation to the ICU staff.

Conclusion

EOL care is not a topic that everyone likes to talk about despite the fact that death is the only thing that is guaranteed to everything that lives and breathes. People shy away from having conversations about death with their immediate families as well as their friends. Many do not even possess an advanced directive that will inform healthcare professionals how to manage their health options in the event they are not able to speak up for themselves.

This educational tool was adapted to provide nurses the needed support to initiate conversations that are nonthreatening, conversations that would help them to feel comfortable with their patients and families. The ultimate intent of this tool was to reduce the silence between nurses, terminally ill patients, and their families and to show compassion in care with all patients especially to those whose diagnoses are considered incurable. DNP nurses are seen as leaders and advocates, and it is important for DNP nurses to develop evidence-based projects that can be shared with others, a project that may be researched further. The topic EOL has evolved into a major concern of the public despite all the funding donated by RWJF and the IOM; there is still a gap in the

improvement of care for terminally ill patients and their loved ones. The time has come when policy makers and healthcare organizations need to listen to the stories of patients and their loved ones and devise new strategies for EOL care because the old strategies are not working. Change can be made by effective listening. Death needs to be accepted by everyone as a life event and not a medical failure. Policy makers and healthcare organizations need to have meaningful conversations with members of the public and the media, engaging them in the conversation that everyone dreads to speak about. Perhaps by listening to others who are not directly involved in healthcare, communities can do their part in making the dying experience a good one for all patients.

Aside from sharing my findings with others through small group discussions and meetings, I plan to look at publication so that the findings of this project can be disseminated. Communication is important in all facets of life (Madhukar, 2005); therefore, helping the public understand that they have choices in their care which begins when the diagnosis is first made, which is vital. Patients need to be aware that they should engage their physicians in conversations so that as their condition declines, it can be easily accepted. My ultimate goal is to go out in the community to help with the education of those in need, especially the elderly population.

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Appendix A: Data

The following tables and figures show data collected during this quality improvement project.

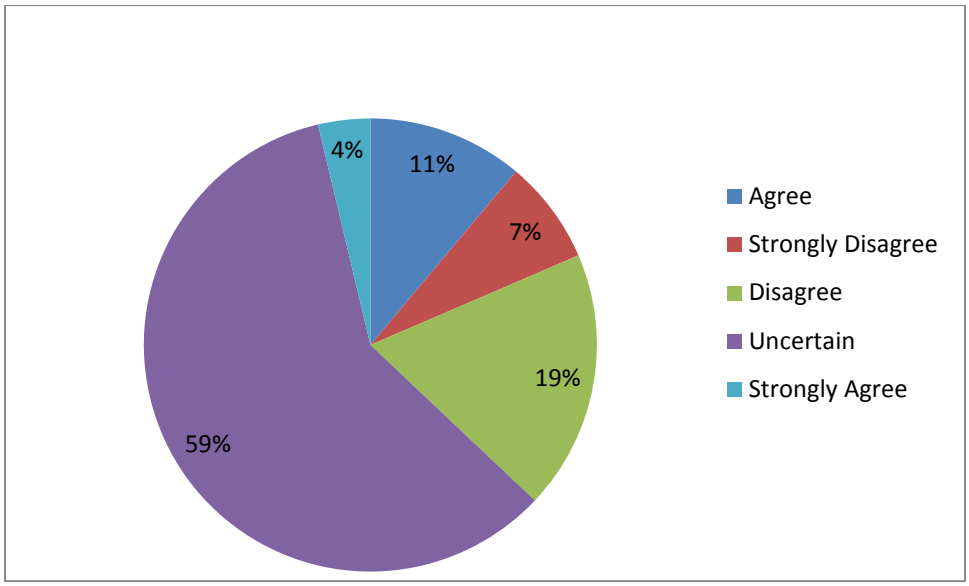

Figure A.1. Responses from Question 7 from End of Life Project Questionnaire

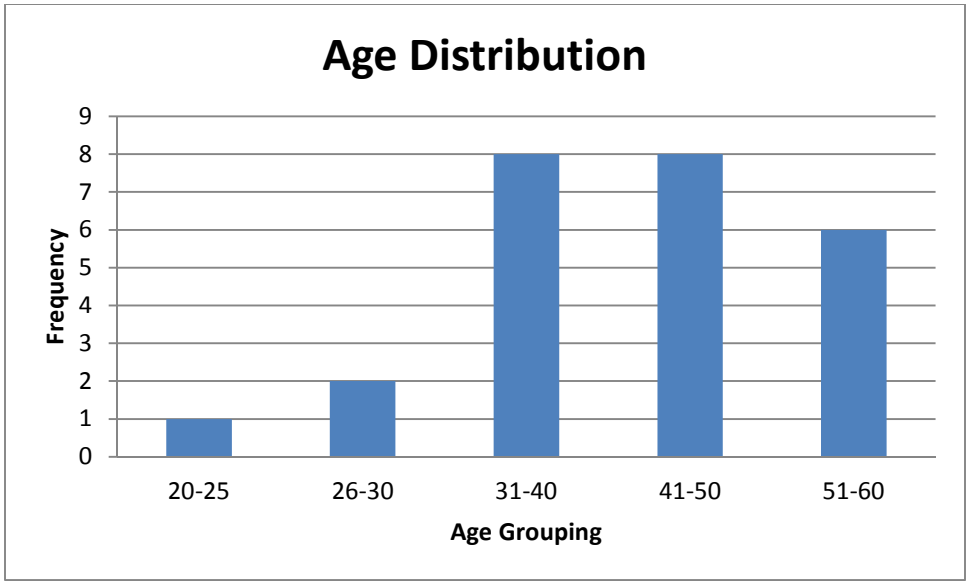

Figure A.2. Age distribution for EOL

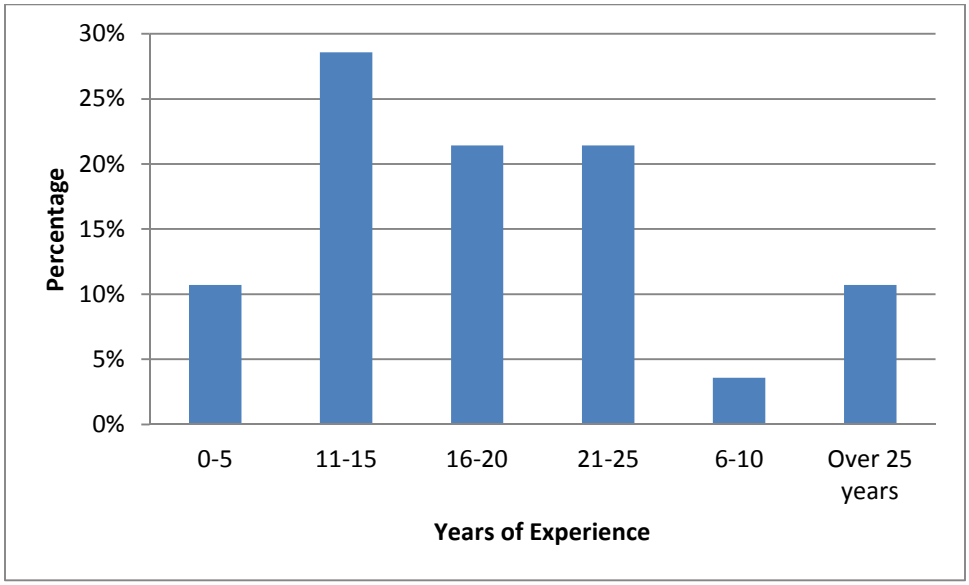

Figure A.3. Years of experience of participating nurses.

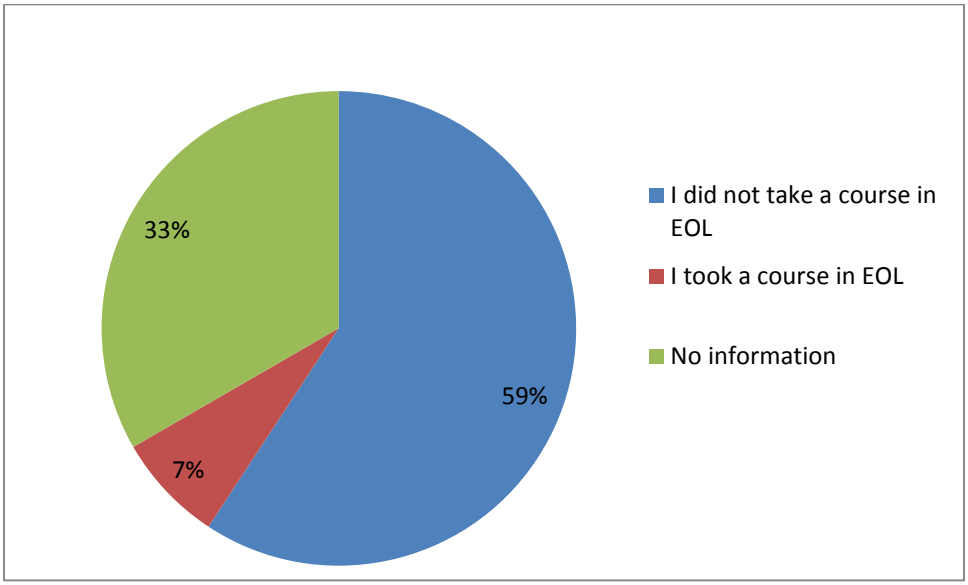

Figure A.4. Previous education on death and dying

Appendix B: Discussion Questions

The following questions were used to begin discussions at different times of care.

1. What is your understanding about your diagnosis and treatment options?
2. Which symptoms bother you the most?
3. How has your illness interfered with your daily activities?
4. How do you think your quality of life should be?
5. Who is responsible for your healthcare decisions in the event you are not able to communicate this?
6. Do you have a signed Advanced Directive?

These are sample questions adapted from the ELNEC training, permission for use was granted.

Appendix C: Permissions Granted

The following e-mails show the permissions granted for use of information contained within this paper and used for this project.

Ferrell, Betty
To
Me
Dec 28 at 12:28 AM
You are welcome to quote from the book and just reference accordingly to credit the chapter authors.
If you send me your address can mail you ELNEC Core and critical care CDs.
All our courses are listed on the ELNEC website.
Betty

Sent from my iPhone

Get to know me poster (3)
Me Dear Dr. Billings, My name is Pervell Dunbar a doctoral student at Walden University, my final project is on end of life and the conversations that are not happening in the ICU between nurses, patients and families.
Sep 23 at 5:59 PM
Billings, J. Andrew, MD.
To
Me
Sep 24 at 9:39 AM
You should feel free to use or alter the Get to Know Me poster but include some attribution to the MGH.

The nurses handled the poster but my impression is that many families were very pleased to create one and happily took them home. The posters were generally created very soon after admission — within a day or two. The posters are part of welcoming the patient/family to the ICU and showing our interest in a fuller picture of the patient than is provided in routine intakes.

Best wishes,

J. Andrew Billings, MD
11 1Ž2 Hilliard Street
Cambridge, MA 02138
617.876.8106

Appendix C: EOL Project Questionnaire

The following questionnaire was used for nurses that participated in the project.

End of Life Project Questionnaire

Instructions: Please complete the following items by placing a check in front of the appropriate response. There is no need to write your name.

1. **Age**

_ 20-25

_ 26-30

_31-40

_ 41-50

_ 51-60

2. Years of Nursing Experience

_ 0-5 years

_ 6-10 years

_ 11-15 years

_ 16-20 years

_ 21-25 Years

_ Over 25 Years

3. Type of Basic Nursing Preparation

_ Diploma

_ ADN

_ BSN

4. Gender

_ Male

_ Female

5. **Previous Education on Death and Dying**

_ I took a course in death and dying as part of my basic nursing education

_ I did not take a specific course, but material on death and dying was included in my nursing courses.

_ No information on death and dying was included in my nursing education

Instructions: Circle the letter following each statement which corresponds to your own personal feeling about the attitude or situation presented.

SD= Strongly Disagree

D = Disagree

U = Uncertain

A = Agree

SA = Strongly Agree

1. Giving nursing care to the dying person is a worthwhile learning experience
   SD D U A SA
2. It is difficult to form a close relationship with the family of a dying patient
   SD D U A SA
3. The dying patient should not be allowed to make decisions about his/her physical care

   SD D U A SA
4. It is beneficial for the dying person to verbalize his/her feelings and wishes.

   SD D U A SA
5. Dying patients and their families should be given honest answers about their conditions

   SD D U A SA
6. Educating families about death and dying is not a nursing responsibility

   SD D U A SA
7. Family members who stay close to a dying patient often interferes with the professional's job
   SD D U A SA
8. I would be uncomfortable talking about impending death with the patient and their family
   SD D U A SA
9. Caring for the patients' family should continue throughout the period of grief and bereavement

   SD D U A SA
10. There are times when death is welcomed by the dying person.

SD D U A SA